



Kansas Department of Health and Environment

Long Term Care Program

FACT SHEET II

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Fact Sheet II is published by the Kansas Department of Health and Environment and sent to all assisted living, residential health care, adult day care and home plus facilities. This newsletter provides important up-to-date information concerning the health care industry.

Immunization Records for Employees

There are no specific regulations for long term care facilities concerning immunization histories for employees. Based on documentation in the literature concerning nosocomial transmission, health care workers are at significant risk for acquiring and transmitting measles, mumps, rubella, hepatitis B, varicella, and influenza. Vaccination is strongly recommended to safeguard the health of workers, and to protect residents from becoming infected. Facilities are encouraged to formulate a comprehensive immunization policy for all health care workers.

An immunization record should be maintained for all employees reflecting documented proof of immunity to the diseases for which health care workers are at most risk. The immunization record should include all vaccinations administered, the date of administration, and the agency providing vaccination. Employees should be asked to provide documentation of their immunization history prior to employment.

Attached to this issue of the FACT SHEET is a listing of infectious diseases and recommendations for immunization.

Semi-Annual Report

Enclosed with this Fact Sheet is the Long Term Care Semi-Annual Report for the 6 month reporting period of January 1 through May 31, 2000. THE DEADLINE FOR FILING THIS REPORT IS August 15, 2000. This report shall be filed with the Bureau of Health Facilities, Kansas Department of Health and Environment. All **NURSING FACILITIES, ASSISTED LIVING FACILITIES, RESIDENTIAL HEALTH CARE FACILITIES, NURSING FACILITIES FOR MENTAL HEALTH, and INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED** are required to complete this report by indicating resident and employee data for the six month period January 1- May 31, 2000.

Refer questions regarding this form to Patricia Maben, Director, Long Term Care Program, (785) 296-1246.

Involuntary Discharge From an Adult Care Home

Involuntarily discharging a resident should be a rare occurrence. Facilities must ensure that the reason for the involuntary discharge meets regulatory requirements. Residents may be involuntarily discharged if the following conditions are met:

1. The resident's physician has documented in the resident's clinical record that the resident's welfare and the resident's needs cannot be met by the adult care home.

The case must be made that the resident is in need of services which the facility cannot provide.
2. The resident's physician has documented in the resident's clinical record that the resident's health has sufficiently improved and the resident no longer needs the services provided by the adult care home.
3. A physician has documented in the resident's record that discharge or transfer of the resident is necessary because the health or safety of other individuals in the adult care home is endangered.
4. The resident has failed after appropriate notice to pay the rates and charges due the adult care home.

Documentation should be available in the business records that the facility has made an effort to collect the monies owed.

All residents have the right to report an involuntary discharge to the KDHE complaint line for review.

Hospice Referrals

Medicare beneficiaries residing in an adult care home can elect to receive the Medicare hospice benefit. It is the responsibility of the facility to ensure that the resident and/or the resident's legal representative are provided the opportunity to select the hospice of their choice to provide that service. Section 1802 of the Social Security Act gives each Medicare beneficiary the right to obtain health services from any institution...(hospice)... The resident has the right to choose the agency. It is the responsibility of the facility to inform the resident of the hospices which operate within the area the facility is located.

Verification of Licensure for Licensed Nurses

It is a good employment practice for facilities to confirm the licensure status of licensed nurses prior to employment. Employers can gain access to licensure data on the Internet through the Information Network of Kansas (INK). The Board of Nursing has announced that licensure data will be updated every Monday morning, with the exception of holidays and on the second working day prior to the end of each month. Currently INK charges \$75 for the first year of service and \$60 per year thereafter. In addition there is a 25¢ charge for access event.

Employers may request written verification of licensure. The Kansas Board of Nursing verification charges are as follows: five names or less - \$2.00; six to ten names - \$3.00; 11-15 names - \$5.00; and more than 20 names, add \$1.50 per five names.

Phone verification of a nurse's license is available on the last two working days of the month. There

is no charge for phone verification.

For further information contact the Kansas Board of Nursing at 785-296-4929.

ANE Prevention Training

Last year the Kansas Association of Homes and Services for the Aging received a grant for a train the trainer program in the prevention of abuse, neglect and exploitation. Seventy individuals attended the training. A number of these individuals have indicated they would be willing to provide training in facilities other than their own. Contact Edith Stunkel, Director of Planning and Research at KAHSa for more information. 785-233-7443 ext. 223.

Credentialing Update -

HOC Advisory Group: Partnership Success Stories

During the spring of 1999, Health Occupations Credentialing needed an avenue for informal discussion with credentialing stakeholders. The HOC Advisory Group was conceived to be a sounding board for concepts and changes HOC contemplated and customers wanted, as well as developing a partnership in the decision-making and implementation of such changes. This venue has provided an informal setting for sharing ideas and recommendations for HOC program enhancements. The mailing list includes representatives of KPNHAA, KAHSa, KHCA, KHCA (home health), KDOA, the Office of the LTC Ombudsman, educational institutions and others. Significant topics for this group include:

- **Recertification for nurse aides and home health aides.** Assessment was that recertification did not hold much advantage to the agency, the industry or the aides at this point in time. Several proposals were constructed; these are on file and available, should the issue resurface.
- **Certified Physical Therapist Assistants and Registered Occupational Therapy Assistants bridge course** (12 hours didactic, 12 hours clinical). Candidates complete the course and pass the state CNA test. The course is taught by a department approved nurse aide instructor. (Copies of the curriculum are available from Martha Ryan, 785-296-0058 or MRyan@kdhe.state.ks.us.)
- **Automating the certification tests.** After consideration, the group determined that the industry really wanted more frequent testing options. A "win-win" scenario: the structure of the test administration does not change, but employers may now opt to schedule an **alternative test certification date** by contacting HOC and following the steps outlined in policy. (Available by contacting Betty Domer, 785-296-1250 or BDomer@kdhe.state.ks.us).
- **Rewrite of the Certified Medication Aide curriculum and test.** The Advisory Group recommended persons for the committees; there has been completion of a blueprint for the curriculum and commitment to rewrite the curriculum and tests by committee members.
- KAHSa and HOC collaborated in **a full-day training session in Wichita for instructors of nurse aide courses**. KAHSa developed the program, HOC provided training needs from a survey of instructors (included the program brochure in the Update newsletter) and participated in a panel discussion.

- **Criminal Background Checks Program and House Bill 2700.** A Report to the Legislature on the program operations was provided by KDHE during this past session. Staff identified several improvements and enhancements believed to be beneficial. Concurrently, the long term care industry proposed changes to the criminal background check law, KSA 39-970 and KSA 65-5117 (House Bill 2700). Core topics: broadened criminal history record information distribution (maintained by the Kansas Bureau of Investigation); KDHE providing results for all inquiries; a prescribed response time for inquiries; and, private contractors providing the service. HB 2700 represented an opinion the industry had not expressed during the deliberations of the original legislation; it also breached legal parameters which govern the criminal history record information. The statute is written to protect frail and elderly from individuals whose criminal conviction record identifies a serious "crime against persons." There is a specific list of crimes for which a person must not work in an adult care home or home health agency. The proposals under HB 2700 portended employers using the criminal records as an employment screening tool without identifying how hiring decisions could place the employer in legal jeopardy. This issue was identified during legislative hearings. The complicated legal and administrative issues prompted HOC to use the Advisory Group as a forum to facilitate some of the enhancements staff had identified, implement substantial changes within existing statutory language, and perhaps offer a proposal for future legislative consideration.

The Advisory Group has developed a history of creative problem-solving and improved understanding among its members. If anyone is interested in participating or receiving minutes from the meetings, please contact Lesa Bray at 785-296-1281 or Martha Ryan at 785-296-0058.

Automation of KNAR

HOC has put forth a **proposal** to the KDHE Division of Information Systems to automate the Kansas Nurse Aide Registry (KNAR). Automating the KNAR could allow users to enter and receive information directly from the registry, improving accessibility of the basic data and allowing the registry operator to respond to more complex calls. Users of the registry would have the convenience of accessing the registry 24 hours a day, 7 days a week compared to the current six hours a day, Monday through Friday. This proposal is in the very early stage of administrative consideration. Several other states operate automated registries. Some states have eliminated operator-assistance all together, though this is not the intent for Kansas. As this proposal wends its way through the review and approval process, the industry will be kept informed. If you have concerns, comments or suggestions, feel free to email Steve Irwin: Sirwin@kdhe.state.ks.us.

Resources for Quality Care

The following journal articles provide good information.

Gaston-Johansson, F., Johansson, F., and Johansson, N. (1999). Under treatment of Pain in the Elderly: Causes and Prevention. *Nursing Home Medicine: The Annals of Long-Term Care*, 7[5]:190-196.

A high percentage of elderly report experiencing acute and chronic pain. Successful pain management requires an analysis of the causes, a framework for understanding the pain, and a simple protocol to assist staff in assessing, documenting and treating pain in the elderly. This article includes strategies for improving the treatment of pain in the elderly including individuals with dementia.

Douzjian, M., Wilson, C., Shultz, M., Berger, J., Tapnia, J., and Blanton, V. (1998). A Program to Use Pain Control Medication to Reduce Psychotropic Drug Use in Residents with Difficult Behavior. *Nursing Home Medicine: The Annals of Long-Term Care*. Website - <http://www.mmhc.com/nhm/articles/NHM9804/Douzjian.html>

This article reports on an informal study using pain medication orders for 650 mg. of acetaminophen three times a day in 10 residents with difficult behaviors who were also receiving psychotropic medication. At the end of the study, behavioral symptoms had decreased by 63% and seventy five percent of psychotropic medications were discontinued.

ANE ISSUE STATISTICS 3/1/00 to 5/31/00
Complaint Calls Assigned for Investigation

<u>ANE Investigations</u>		<u>Care Issues Investigated</u>	
Total	401	Total	350
Mar	164	Mar	122
Apr	109	Apr	106
May	128	May	122

*Licensure Category	Civil Penalties				Correction Orders			
	2000 Quarters							
	1 st	2 nd	3 rd	4 th	1 st	2 nd	3 rd	4 th
Inadequate or inappropriate hygiene and skin care	-				2			
Inadequate or unqualified staffing	-				4			
Inoperable or inaccessible call system	-				0			
Inappropriate or unauthorized use of restraints	-				0			
Unsafe medication administration or storage	-				2			
Inadequate nursing services other skin care	-				2			
Inadequate or inappropriate asepsis technique	-				0			
Inadequate or inappropriate dietary/nutritional services	-				6			
Unsafe storage or hazardous or toxic substances	-				1			
Failure to maintain equipment	-				0			
Resident right violations	-				7			
Unsafe high water temperature	-				0			
Inadequate hot water	-				0			
General sanitation and safety	-				3			
Other (including inappropriate admission)	-				1			
Inadequate rehabilitation services	-				1			
Civil Penalties	0							
Correction Orders	11							
Bans on Admission	4							
Denials	0							

*A correction order or civil penalty may consist of multiple issues summarized within the licensure categories above.

FEDERAL REMEDIES -CATEGORIES 2 & 3 - 2000 Quarters

	1 st	2 nd	3 rd	4 th
Civil Monetary Penalties Recommended	18			
Denial of Payment for New Admissions Imposed	27			
Terminations				

I. MEASLES

All health care workers* born on or after 01/01/57 must provide adequate proof of immunity to measles with one of the following:

- A. History of physician-diagnosed measles.
- B. Serologic evidence of immunity.
- C. Documentation of adequate vaccination.

MUMPS

All health care workers* born on or after 01/01/57 must provide adequate proof of immunity to mumps with one of the following:

- A. History of physician-diagnosed mumps.
- B. Serologic evidence of immunity.
- C. Documentation of adequate vaccination.

RUBELLA

All health care workers* born on or after 01/01/57 must provide adequate proof of immunity to rubella with one of the following:

- A. Serologic evidence of immunity.
- B. Documentation of adequate vaccination.

• Adequate Vaccination

Adequate vaccination includes receipt of 2 doses of live Measles-Mumps-Rubella (MMR) vaccine at least 1 month apart on or after 12 months of age.

• Special Considerations

Adults born before 1957 can be considered immune to measles, mumps, and rubella.** However, since measles cases and related outbreaks have occurred in health care workers in this age group, health facilities should consider offering at least one dose of measles-containing vaccine to such workers who lack proof of immunity to measles.

• Serologic Screening

Serologic screening need not be done before vaccinating against measles and rubella unless the health care facility considers it cost effective. Serologic testing is not necessary for persons who have documentation of appropriate vaccination or other acceptable evidence of immunity. Testing before vaccination is appropriate only if tested persons identified as nonimmune are subsequently vaccinated in a timely manner, and should not be done if the return and timely vaccination of those screened cannot be ensured.

• Contraindications to Vaccination

Severe allergic reaction to a prior dose or a vaccine component
Pregnancy
Immunosuppression***
Moderate or severe acute illness
Receipt of an antibody-containing blood product

*All health-care workers (i.e., medical or nonmedical, paid or volunteer, full time or part time, student or non-student, with or without patient-care responsibilities) who work in health-care institutions (e.g., inpatient and outpatient, public and private) should be immune to measles and rubella.

**Birth before 1957 is not acceptable evidence of rubella immunity for women who can become pregnant because rubella can occur in some unvaccinated persons born before 1957 and because congenital rubella syndrome (CRS) can occur in offspring of women infected with rubella during pregnancy.

***MMR vaccination should be considered for asymptomatic HIV patients.

II. HEPATITIS B

The risk for acquiring hepatitis B infection from occupational exposures is dependent on the frequency of percutaneous and mucous exposures to blood or body fluids containing blood. Any health care worker may be at high risk for hepatitis B infection depending on the tasks performed. Employees performing tasks involving exposure to blood, blood-contaminated body fluids, other body fluids, or sharps should be vaccinated. The Occupational Safety and Health Act (OSHA) Federal Standard mandates that hepatitis B vaccine be made available to all occupationally exposed health care workers.

• Vaccination

Adequate vaccination for adults includes receipt of 3 doses of hepatitis B vaccine with at least 1 month between the first and second dose, at least 2 months between the second and third dose, and at least 4 months between the first and third dose.

• Prevacination Serologic Screening

Prevaccination serologic screening for previous infection is not indicated for persons being vaccinated because of occupational risk unless the health care facility considers it cost effective. The vaccine produces neither therapeutic nor adverse effects on infected persons.

• Postvaccination Serologic Screening

Testing for immunity 1-2 months after completion of the vaccine series is advised for persons whose subsequent management depends on knowing their immune status, such as health care workers with blood or body fluid contact. Health care workers who do not respond to an initial vaccine series should receive an additional 3-dose series of hepatitis B vaccine with retesting performed 1-2 months after completion of the second series. If the health care worker does not respond to the second series of hepatitis B vaccine further revaccination is not indicated.

• Duration of Immunity

Vaccine-induced antibodies to the hepatitis B virus decline gradually over time. Persons who initially respond to vaccination will lose detectable antibodies over a 12 year period, however studies indicate that immunity continues to prevent clinical disease. Booster doses of hepatitis B vaccine are not considered necessary, and periodic testing to monitor antibody concentrations is not recommended.

• Contraindications to Vaccination

Severe allergic reaction to a prior dose or a vaccine component
Moderate or severe acute illness

Postexposure Prophylaxis

Source of Contact— Exposed Person	HBsAg* Positive	HBsAg* Negative	Source not tested or unknown
Unvaccinated	HBIG• x 1 and initiate vaccine series	Initiate vaccine series	Initiate vaccine series
Vaccinated— known responder	No Treatment	No Treatment	No Treatment
Vaccinated— known nonresponder	HBIG• x 2 OR HBIG• x 1 and initiate revaccination	No Treatment	If know high-risk source, may treat as if source were HBsAg* positive
Vaccinated— response unknown	Test exposed person for anti-HBs:• 1. If adequate—no TX 2. If inadequate—HBIG• x 1 and booster	No Treatment	Test exposed person for anti-HBs:• 1. If adequate—no TX 2. If inadequate—initiate revaccination

*HBsAg (Hepatitis B surface antigen)

•HBIG (Hepatitis B immune globulin)

•anti HBs (Antibody to hepatitis B surface antigen)

CDC/1998

III. VARICELLA

All health care workers* should be immune to varicella. Vaccination is strongly recommended for susceptible employees who have close contact with patients at high risk for serious complications from varicella infection.** Only immune personnel should care for patients suspected of having varicella. A reliable history of chickenpox is a valid measure of immunity to varicella.

- **Vaccination**

Adequate vaccination for individuals 13 years of age and older includes receipt of 2 doses of varicella vaccine at least 1 month apart on or after 12 months of age.

- **Prevaccination Serologic Screening**

Serologic screening of personnel who have a negative or uncertain history of varicella is likely to be cost effective.

- **Postvaccination Serologic Screening**

Routine serologic screening after vaccination with 2 doses of varicella vaccine is not considered necessary because 99% of persons become seropositive after the second dose.

- **Postexposure Vaccination**

Vaccination should be considered for unvaccinated health care workers who are exposed to varicella and whose immunity is not documented. However, the protective effects of postexposure vaccination are unknown. Workers vaccinated after an exposure should be managed in the manner recommended for unvaccinated persons.

- **Postexposure Management**

Susceptible workers exposed to varicella are potentially infective 10-21 days after exposure. They should be relieved from direct patient contact during this period and may need to be furloughed. If workers develop chickenpox, varicella lesions must be crusted before they return to direct patient contact. Receipt of varicella zoster immune globulin (VZIG) after exposure can be costly, does not necessarily prevent varicella, and may prolong the incubation period by a week or more. The period of removal from direct patient contact should be extended by one week or more if an employee receives VZIG.

- **Breakthrough Infection in Health-Care Workers**

Vaccination and subsequent seroconversion does not always result in full protection against disease. Breakthrough infections have occurred in vaccinees after exposure to natural varicella virus. However, vaccinees who develop varicella generally experience a milder form of disease. If a vaccinated health care worker is exposed to varicella, the following measures are recommended:

- a) serologic testing for varicella antibody immediately after exposure
- b) retesting 5-6 days later to determine if an anamnestic response is present
- c) possible furlough or reassignment of personnel without detectable antibody

- **Vaccine Virus**

The risk of transmission of vaccine virus from a vaccinated person to a susceptible contact is very low. The benefits of vaccinating susceptible health care workers clearly outweigh the potential risks. Transmission of vaccine virus occurs primarily when vaccinees develop a vaccine-associated rash. Employees who develop a rash following vaccination should avoid contact with patients at high risk of serious complications from varicella infection.**

- **Contraindications to Vaccination**

Severe allergic reaction to a prior dose or a vaccine component
Pregnancy
Immunosuppression
Moderate or severe acute illness
Receipt of an antibody-containing blood product

*All health care workers (i.e., medical or nonmedical, paid or volunteer, full time or part time, student or non-student, with or without patient care responsibilities) who work in health care institutions (e.g., inpatient and outpatient, public and private) should be immune to varicella.

** Pregnant women, premature infants born to susceptible mothers, infants born at <28 weeks' gestation or who weigh ≤ 1000 grams regardless of maternal immune status, and persons immunocompromised because of immune deficiency diseases, HIV infection, leukemia, lymphoma or generalized malignancy, or immunosuppressed as a result of therapy with corticosteroids, alkylating drugs, antimetabolites, or radiation.

IV. INFLUENZA

Nosocomial transmission of influenza disease, including transmission from health care workers to patients, may occur during community influenza outbreaks. The transmission of influenza among health care workers often causes absenteeism and considerable disruption of health care. Influenza outbreaks may result in morbidity and mortality in patients, particularly those who reside in long-term care facilities. To reduce the spread of influenza among workers and patients, the following health care workers should be vaccinated in the fall of each year:

- a) Employees who attend patients at high risk of complications* from influenza disease, whether the care is provided at home or in a health-care facility.
- b) Employees aged ≥ 65 years of age.
- c) Employees with certain chronic medical conditions (e.g., persons who have chronic disorders of the cardiovascular or pulmonary systems; persons who required medical follow-up or hospitalization within the preceding year because of chronic metabolic disease [including diabetes], renal dysfunction, hemoglobinopathies, or immunosuppression [including HIV infection]).
- d) Pregnant employees** who will be in the second or third trimester of pregnancy during influenza season.

- **Vaccination**

Adequate vaccination for individuals 9 years of age and older is receipt of 1 dose of influenza vaccine annually. The optimal time for vaccination is October to mid-November to correspond with the peak activity period (late December to early March) for influenza. However, vaccine may be given anytime during the influenza season.

- **Duration of Immunity**

Immunity following influenza vaccination rarely exceeds 1 year.

- **Vaccine Efficacy**

Vaccine efficacy varies depending on the circulating strain and the age and underlying illnesses of the vaccine recipient. If the vaccine strain is similar to the circulating strain, 90% of healthy young adults will be protected from illness. Vaccine is only 30% to 40% effective in preventing illness among chronically-ill elderly persons. However, the vaccine is 50% to 60% effective in preventing hospitalization and 80% effective in preventing death in the elderly.

- **Contraindications to Vaccination**

Severe allergic reaction to a prior dose or a vaccine component***
Moderate or severe acute illness

*Patients at high-risk of complications include persons aged ≥ 65 years of age; residents of nursing homes and other chronic-care facilities that house persons of any age who have chronic medical conditions; adults and children who have chronic disorders of the pulmonary or cardiovascular systems, including children with asthma; adults and children who have required regular medical follow-up or hospitalization during the preceding year because of chronic metabolic diseases (including diabetes mellitus), renal dysfunction, hemoglobinopathies, or immunosuppression (including immunosuppression caused by medications); children and adolescents (aged 6 months to 18 years of age) who are receiving long-term aspirin therapy and therefore might be at risk for developing Reye's syndrome after influenza; and women who will be in the second or third trimester of pregnancy during the influenza season.

** Studies suggest that pregnant women may be at increased risk for serious medical complications of influenza. Vaccination is recommended for women who will be in at least the 14th week of gestation during influenza season, generally women who become pregnant between the first of March and the first of September. No evidence exists of risk to mother or fetus when the vaccine is administered to a pregnant woman with an underlying high-risk condition.

***A history of anaphylactic hypersensitivity to egg ingestion is a contraindication to vaccination.

References

1. Centers for Disease Control and Prevention. Immunization of Health-Care Workers. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report. 1997;46(RR-18): 1-42.
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4. Centers for Disease Control and Prevention. Prevention and Control of Influenza. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report. 1998;47(RR-6): 1-26.
5. Centers for Disease Control and Prevention. Measles, Mumps, and Rubella Vaccine Use and Strategies for Elimination of Measles, Rubella, and Congenital Rubella Syndrome and Control of Mumps. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Morbidity and Mortality Weekly Report. 1998;47(RR-8).